STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445358	A. BUILDING _____ B. WING _____	12/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEBRIDGE HEALTH CARE CENTER	115 WOODLAWN DRIVE JOHNSON CITY, TN 37604

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a care plan with measurable goals and interventions specific to the resident's needs for two residents (#151, #23) of forty-one residents reviewed. The findings included: Resident #151 was admitted on July 7, 2011, with diagnoses including Senile Dementia, Senile and Presenile Organic Psychotic Conditions, Senile Dementia with Delusional features, Depressive	F 279	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Lakebridge Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Lakebridge Health Care Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid Program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal, and any other applicable legal or administrative proceedings. This plan of correction should not be taken as establishing any standard of care and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable in administrative, civil or criminal proceedings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nydia Bays	Administrator	12/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 Disorder, and Alzheimer's Disease. Review of the Minimum Data Set (MDS) dated July 13, 2011, revealed the resident's cognitive score on the Brief Interview for Mental Status was 2 of 15 with 15 being the highest possible score and 2 indicating severe cognitive deficits. Review of the history and physical dated September 1, 2011, revealed, "...severe dementia and inability to talk...Mental status decline; increased behaviors..." Review of the Physician Emergency Department (ED) Note dated September 9, 2011, Active Problems, revealed, Agitation, Anxiety, and Schizoaffective Disorder. Continued review revealed the resident was seen in the ED for evaluation related to behaviors. Continued review revealed, "...plan: no organic cause of pts (patient's) aggressiveness...most likely needs...meds adjusted...pt (patient) managed in ED (Emergency Department) with distraction and Haldol (antipsychotic)...Chief complaint: Pt. brought by EMS (Emergency Medical Services)...for altered mental status change, being combative..." Review of the Mental Health Services note dated September 21, 2011, revealed, "...Dementia, Agitation/Aggression - PRN (as needed) Ativan (anxiolytic) added, Continues to strike out at staff when providing care or attempting to redirect, wandering has increased...Start Depakote low dose for agitation and aggressive behaviors. Watch closely...Has caused two staff members to have bruising to the face from...aggression..."	F 279	F279 12/21/11 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care but that in order to respond to this citation from the surveyors the facility is taking the following additional actions. **Corrective Actions for Targeted Residents:** Resident # 151and # 23 care plan goals were revised by the care plan team . Revisions were as follows: Revision for #151 Problem/Strengths: Often resident can have increased episodes of agitation and frustration secondary to hearing loss and dementia. Goal: Resident will have no more than 2 behavior episodes a week by next review date. Revision for #151 Problem/Strengths: Resident assessed and found to be at nutritional risk. Goal: Resident will have no more than 5 % weight loss by next review. Revisions # 23. Problem/Strengths: Resident assessed and found to be at nutritional risk. Goal: Resident will have no more than 5% weight loss by next review.	

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F 279	Continued From page 2 Review of the resident's care plan dated October 19, 2011, and reviewed October 27, 2011, revealed, "Problems/Strengths, H & P states resident can become angry and frustrated in new environments due to hearing issues. Goal: Will attempt to prevent s/sx (signs and symptoms) of frustration and agitation..." Interview with the MDS Coordinator on Dec. 7, 2011, at 12:30 p.m., in the MDS office confirmed the resident's care plan goal was not measurable and specific for the resident's behavior. Medical record review for the same resident (#151) for nutritional concerns revealed the resident's admission weight on July 6, 2011, was 150 pounds, with a percutaneous endoscopic gastrostomy (PEG) tube in place for nutritional support. Continued review revealed the resident had a diagnosis of Dysphagia (difficulty swallowing). Review of the hospital history and physical dated September 1, 2011, stated, "...history of dementia and PEG tube placement for failed modified barium swallow and nutritional support who presents with second episode of pulled tube...has been eating at the nursing home and while here...discussed case in depth with...Power of Attorney...who wishes that the PEG tube be left out...could increase risk of aspiration and...is aware of this risk..." Medical record review of the facility's weight record for resident #151 revealed the following weights: Date: 07/18/2011; Weight: 142 Date: 08/02/2011; Weight: 142	F 279	**Identification of Other Residents with Potential to be Affected** Care Plans with Behavior and Nutritional at risk goals were reviewed by MDS Coordinator and MDS Assessment Nurse on 12/14 and 12/15/11 to ensure that they included measurable and specific goals. **Systematic Changes** The care plan team which consist of MDS Coordinator, Assessment Nurse, Social Services Director, Dietary Manager and Activity Director were inserviced on 12/9/2011 by Director of Nursing to ensure that care plans contain measurable and specific goals for each resident.additonal inservice on care plans will be held on 12/22/11by Nurse Consulant . **Monitoring** Measures to assure compliance include monthly Performance Improvement audits by the Director of Nursing and Assistant Director of Nursing. The Director of Nursing and the Assistant Director of Nursing will review the care plan goals for residents with behavior issues and /or nutritional at risk problems. Findings from the audits will be reported and discussed during the Performance Committee meeting which consist of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS & Assessment Nurse,, Housekeeping Supervisor, Maintenance Director, Social Services Director,	

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F 279	Continued From page 3 Date: 09/02/2011; Weight: 131 Date: 12/01/2011; Weight: 144 Review of the resident's care plan dated October 24, 2011, section titled, Problems/Strengths, revealed, "Resident assessed and found to be at nutritional risk r/t (related to) diagnosis with Depression, Dementia, DM II (Diabetes Mellitus Type II). A weight loss. Goals: Maintain wt. as needed. Interview on December 7, 2011, with Minimum Data Set (MDS) Coordinator/Registered Nurse, in the MDS office at 1:50 p.m., confirmed the goal, "Maintain wt. as needed" was not an appropriate, measurable goal for nutritional management. Resident #23 was admitted to the facility May 1, 2002, and readmitted September 19, 2011, with diagnoses including Dementia, Anemia, Congestive Heart Failure, Depression, Asthma, Osteoporosis, and Oral Phase Dysphagia. Medical record review of the MDS dated October 19, 2011, revealed the resident had a score of 9 (out of a possible total of 15) on the Brief Interview for Mental Status, indicating moderate cognitive impairment. Continued review revealed the resident required set up assistance with meals and was able to self feed. Further review revealed the resident had a weight documented of one hundred and six pounds, with a loss of five percent in the past 6 months. Review of the resident's Care Plan, dated July 22,	F 279	The committee's recommendation will be followed up by the MDS Coordinator and Social Service Director.	

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F 279	Continued From page 4 2011, and updated October 26, 2011, revealed a problem "...resident assessed and found to be at nutritional risk..." with a goal of "...Maintain wt. (weight) as needed..." Interventions included "...Provide diet as ordered, Monitor weights monthly and prn (whenever necessary) as ordered, Monitor lab values that reflect nutritional status, Monitor PO (oral) intake, Registered Dietician evaluation yearly and prn, Assess food preferences and update tray card, provide HS (bedtime) snack..." Interview with the Care Plan Coordinator on December 8, 2011, at 4:35 p.m., in the MDS office, confirmed the nutritional risk Care Plan had nonspecific and nonmeasurable goals.	F 279	**F281** Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care but that in order to respond to this citation from the surveyors the facility is taking the following additional actions. **Corrective Actions for Targeted Residents:** On 12/8/11 Resident # 33 was monitored following administration of insulin for any adverse reactions. Blood sugar rechecked at 4:00 p.m. and found to be within normal range. Resident # 33 physician and family were notified of order not followed. No new orders were given.	12/21/11
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for insulin administration for one (#33) of three residents observed for insulin administration of forty-one residents reviewed. The findings included: Resident #33 was re-admitted to the facility on November 15, 2011, with diagnoses including Diabetes, Hypertension, and Congestive Heart Disease.	F 281	Licensed nursing Staff was immediately inserviced on the importance of following MD orders and giving insulin as ordered. **Identification of Other Residents with Potential to be Affected** Medical records of residents requiring Sliding Scale Insulin before meals were reviewed 12/9/2011 by Director of Nursing and Assistant Director of Nursing to ensure that physician orders for insulin were followed correctly. **Systematic Changes** Nursing Staff inservice was repeated on 12/9/2011 by the Director of Nursing and Assistant Director of Nursing. Inserivce consisted of but not limited to ensuring that physician orders being followed and Sliding Scale Insulin being given as ordered.	

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F 281	Continued From page 5 Medical record review of the December 2011, physician orders revealed "...Humulin R (Regular, type of insulin)...Inject sliding scale insulin subcutaneously before meals & (and) at bedtime..." Observation on December 8, 2011, at 1:40 p.m., in the resident's room revealed Registered Nurse (RN) #1 administered 6 units of Humulin R insulin subcutaneously. Interview on December 8, 2011, at 1:50 p.m., with RN #1, outside of the resident's room, confirmed RN #1 administered the sliding scale insulin after the resident ate lunch; and the insulin was not given as ordered by the physician.	F 281	**Monitoring** The Director of Nursing and Assistant Director on Nursing will do rounds daily observing Sliding Scale Insulin administration to ensure sliding scale insulin is given as ordered monthly times 3 months.Results of findings will be reported to the Performance Committee which consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS & Assessment Nurse, Housekeeping Supervisor, Maintenance Director, Social Services Director. Any findings or concerns will be addressed. Results of findings will be reviewed by committee to determine if further monitoring is required.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the pharmacist failed to report irregularities for the physician's orders for one (#16) of forty-one residents reviewed.	F 428	**F428** 12/21/11 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care but that in order to respond to this citation from the surveyors the facility is taking the following additional actions	

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F 428	Continued From page 6 The findings included: Resident #16 was re-admitted to the facility on September 6, 2011, with diagnoses including Urinary Tract Infection, Dementia, Aggression, and Depression. Medical record review of the September, October, November, and December 2011, recapitulation (recap) physician's orders revealed the following medication orders: 1) Haldol (an antipsychotic medication) 4 mg (milligrams) IM (intramuscular) as needed; 2) Haldol 4 mg po (by mouth) q (every) 8 prn (as needed); 3) Lorazepam, (antianxiety medication), 1 mg IM q 6 hours prn; 4) Lorazepam 1 mg po q 6 hours prn; 5) Hydrocodone/Acetamenaphen (narcotic)10/325 mg 1 po prn q day. Continued review revealed no indication for use of the above medications, and no frequency for the use of the narcotic. Medical record review of the consulting pharmacists' reports for September, October, November 2011, revealed no irregularities had been reported for the Haldol, Lorazepam, and Hydrocodone. Interview with the Director of Nursing on December 7, 2011, at 3:40 p.m., in the conference room, confirmed the facility failed to insure documentation for the indication of use for Haldol and Lorazepam. Continued interview confirmed the facility failed to ensure the order for the narcotic included the frequency for the drug to be administered. Continued interview confirmed the consultant pharmacist failed to report the	F 428	**Corrective Actions for Targeted Residents:** Resident # 16 medication administration record was reviewed by Director of Nursing and Consultant Pharmacist. Physician was notified and confirmed indication for use of the medications and frequency for the use of the narcotic. This information wasplaced on the medication administration record on 12/9/2011 by Director of Nursing. **Identification of Other Residents with Potential to be Affected** Medication Administration Records were reviewed by Pharmacist and Director of Nursing on Dec 14, 2011 to ensure that no other irregularities occurred and none were found. **Systematic Changes** Licensed staff inserviced by Director of Nursing and Assistant Director of Nursing to monitor Medication Administration Records and report any irregularities to Director of Nursing. Consultant Pharmacist will review monthly and report placed on chart and also given to Director of Nursing to ensure compliance.	

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F 428	Continued From page 7 irregularities.	F 428	**Monitoring** Measures to assure compliance include monthly Performance Improvement audits by the Consultant Pharmacist,Director of Nursing and Assistant Director of Nursing. They will monitor Medication administration records for any irregularities and these will be discussed during the Performance Committee meeting which consist of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS & Assessment Nurse, Housekeeping Supervisor, Maintenance Director, Social Services Director. The committee's recommendation will be followed up by the Administrator and Director of Nursing.	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	**F431** 12/21/11 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care but that in order to respond to this citation from the surveyors the facility is taking the following additional actions **Corrective Actions for Targeted Residents:** Undated Blood Glucose test strips found on 12/6/2011 was immediately discarded and replaced with new glucose test strips.	

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F 431	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of the manufacturer's recommendations, and interview, the facility failed to ensure the blood sugar test strips were used prior to expiration for four of four medication carts. The findings included: Observation of the medication cart 100-200 with Licensed Practical Nurse (LPN #4) on December 6, 2011, at 2:24 p.m., revealed 2 bottles of blood glucose test strips (one, 1/2 full and one, 3/4 full),opened and undated. Observation of the medication cart 300-400 with LPN #2 on December 6, 2011, at 2:58 p.m., revealed 3 bottles of blood glucose test strips (all, 1/2 full, opened and undated.) Observation of the medication cart 500-600, with Assistant Director of Nursing (ADON) on December 7, 2011, at 10:25 a.m., revealed one bottle of blood glucose test strips (1/2 full, opened and undated.) Interview with the ADON at the time of discovery confirmed the test strips were opened and undated. Observation of medication cart 600-700 with LPN #1, on December 7, 2011, at 10:22 a.m., revealed one bottle of blood glucose test strips (1/2 full, opened and undated.) Review of the manufacturer's recommendations for blood glucose test strips revealed, "Opened blood sugar test strips are to be discarded when	F 431	**Identification of Other Residents with Potential to be Affected** Current residents requiring Accu Checks via usage of Blood Glucose Test Strips have the potential to be affected. **Systematic Changes** Licensed Nursing Staff was inserviced on 12/9/2011 by Director of Nursing. Inservice included following manufactures recommendations and making certain that blood glucose test strips are dated when opened. **Monitoring** Measures to assure compliance include monthly Performance Improvement audits by the Assistant Director of Nursing. The Assistant Director of Nursing will check medication carts three times a week times three months to ensure ongoing compliance.	

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F 431	Continued From page 9 expired or within three months after first opening." Interview with the Assistant Director of Nursing on December 7, 2011, at 1:00 p.m., at nursing station #2, confirmed the facility failed to ensure the test strips were used prior to the expiration date.	F 431	Any undated or expired blood glucose test strips will be discarded. Blood Glucose Test Strip audits will be reported to the Performance Improvement Committee, which consists of Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS & Assessment Nurse, Housekeeping Supervisor, Maintenance Director, Social Services Director. The committee's recommendation will be followed up by the Director of Nursing.	